

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No.

Registrar's No. 8699

DEC 22 1941 791

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 Days
(Specify whether
In this community Unknown
years, months or days)

3. (a) PRINT FULL NAME Steve Dunn

3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive Single years
7. Birth date of deceased July 8, 1856
(Month) (Day) (Year)

8. AGE: Years 85 Months 3 Days 21 If less than one day hr. min.

9. Birthplace Popular Bluff, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Nil.

11. Industry or business Nil.

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Ann Morrison

(b) Address City Hospital #1.

17. (a) BURIAL (b) Date thereof 11-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director William Kelly

(b) Address 1416 N. Tenth Ave

19. (a) NOV 2 1941 (b) J. F. Brubaker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. City Infirmary, 5800 Arsenal St.,
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29
year 1941 hour 3:45 minute P. M.

21. I hereby certify that I attended the deceased from October 15,
19 41 to October 29, 19 41
that I last saw him alive on October 29, 19 41
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work (e) Means of injury

23. Signature M. M. Karl (M. D. or other)

Address 1515 Lafayette Ave., Date signed 10/29/41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No. 4167

P. O. Address. #937 Beech Blk

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.